

The end question is, independently of the harvesting technique, are there segments of “biologically privileged” vein that randomly will have a good outcome in the long term?

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## IS SLIDE TRACHEOPLASTY ALONE ENOUGH TO IMPROVE THE SURGICAL OUTCOME?

### To the Editor:

We read with interest the report by Manning and colleagues<sup>1</sup> on the series of 80 patients with congenital tracheal stenosis undergoing slide tracheoplasty (STP).

They conclude that STP, with the use of cardiopulmonary bypass, is a safe and reliable technique associated with low morbidity and mortality. The title itself underlines the fact that this technique is also pliable because it could also be used with extreme anatomic variants.<sup>2</sup> As reported by Manning and colleagues,<sup>1</sup> the age range of patients undergoing STP can vary from a few days of life to several years, mainly

because tracheal stenosis can occur alone or associated with other anomalies (eg, cardiac, extracardiac, chromosomal) that could precipitate the symptomatology and anticipate the clinical presentation. When the tracheal stenosis is isolated, there are different anatomic variants, such as abnormal bronchial arborization or functional single lungs, that can complicate the preoperative management by requiring mechanical ventilation (27.5%,<sup>1</sup> up to 66%<sup>3</sup>) and sometimes preoperative extracorporeal membrane oxygenation to sustain the hemodynamics.

The use of cardiopulmonary bypass also is routinely used in our center in patients with isolated tracheal stenosis in whom the diameter of the trachea can be as narrow as 1 or 2 mm and conventional endotracheal tubes cannot fit.

The pliability of STP allows the surgeon to extend the incision into one of the bronchi when the stenosis involves segments distal to the carina.<sup>2</sup> However, in the series reported by Manning and colleagues,<sup>1</sup> the involvement of the bronchi in the STP has not been reported. We believe that when a stenosis involves the bronchi, this must be repaired along with the trachea.

STP has currently proved its reliability with a better surgical outcome and lower complication rate when compared with the other techniques.

We disagree with Manning and colleagues’<sup>1</sup> statement that the STP itself is “largely responsible” for their excellent results.

As reported by our institution, the management of these complex patients is multilevel, and intensivists, surgeons, interventional radiologists, pneumonologists, and cardiologists are equally involved. For this reason, we introduced multidisciplinary management with a significant improvement of outcome.<sup>4</sup>

As Manning and colleagues<sup>1</sup> report, 42.5% of the patients (34/80) required at least 1 additional airway intervention, including tracheal dilatation,

stenting, or reoperation. This indicates that STP alone does not always work, because there is still the need for further interventions to achieve an acceptable result.

We believe the management of patients throughout the follow-up period is a key point that must not be forgotten. A better understanding of the mid- and long-term effects of tracheal surgery, such as the function of the airway mucosa or the lung, and above all on the quality of life, will be necessary to achieve a thorough understanding of this very select population.

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## LATE MORTALITY IN OFF-PUMP VERSUS ON-PUMP CORONARY ARTERY BYPASS GRAFTING: A META-ANALYSIS OF PROPENSITY SCORE-ADJUSTED STUDIES

### To the Editor:

We read with great interest the systematic review and meta-analysis by Kuss and associates<sup>1</sup> of propensity score analyses, which found on-pump coronary artery bypass grafting (CABG) superior to on-pump CABG